IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

CERTIFIED MAIL: 7005 1160 0000 1506 9131

December 17, 2008

Nolan L. Hoffer, Administrator
Boise Health & Rehabilitation Center
1001 South Hilton Street
Boise, ID 83705

Provider #: 135077

Dear Mr. Hoffer:

On **December 5, 2008**, a Recertification and State Licensure survey was conducted at Boise Health & Rehabilitation Center by the Bureau of Facility Standards/Department of Health & Welfare to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. **This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies/Plan of Correction, CMS Form 2567, listing Medicare/Medicaid deficiencies, and a similar State Form listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **Please provide ONLY ONE completion date for each Federal/State Tag in column X5 (Complete Date), to signify when you allege that each tag will be back in compliance. NOTE: The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on page 2). After each deficiency has been answered and dated, the administrator should sign both the CMS Form 2567 and State Statement of Deficiencies, in the spaces provided, and return the originals to this office.**

Your Plan of Correction (PoC) for the deficiencies must be submitted by **December 30, 2008**. Failure to submit an acceptable PoC by **December 30, 2008**, may result in the imposition of civil monetary penalties by **January 19, 2009**.

Your PoC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,
- Include dates when corrective action will be completed.

All references to federal regulatory requirements contained in this letter are found in *Title 42, Code of Federal Regulations.*

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS), if your facility has failed to achieve substantial compliance by **January 9, 2009 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **January 9, 2009**. A change in the seriousness of the deficiencies on **January 9, 2009**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **January 9, 2009** includes the following:

Denial of payment for new admissions effective **March 5, 2009**. [42 CFR §488.417(a)]

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying noncompliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **June 5, 2009**, if substantial compliance is not achieved by that time.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will

provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact Loretta Todd, R.N. or Lorene Kayser, L.S.W., Q.M.R.P., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0036, Phone #: (208) 334-6626, Fax #: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **December 5, 2008** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

http://www.healthandwelfare.idaho.gov/_Rainbow/Documents/medical/2001_10.pdf
http://www.healthandwelfare.idaho.gov/_Rainbow/Documents/medical/2001_10_attach1.pdf
http://www.healthandwelfare.idaho.gov/_Rainbow/Documents/medical/2001_10_attach2.pdf

This request must be received by **December 30, 2008**. If your request for informal dispute resolution is received after **December 30, 2008**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact us at (208) 334-6626.

Sincerely,

Lorene Kayser

LORENE KAYSER, L.S.W., Q.M.R.P.
Supervisor
Long Term Care

LKK/dmj

Enclosures

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 135077	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: 12/5/2008
NAME OF PROVIDER OR SUPPLIER **BOISE HEALTH & REHAB CENTER**	STREET ADDRESS, CITY, STATE, ZIP CODE **1001 SOUTH HILTON STREET BOISE, ID**		

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 204	483.12(a)(7) ORIENTATION FOR TRANSFER OR DISCHARGE A facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility failed to ensure residents' belongings were not left behind or lost upon transfer or discharge. This was true for 1 of 3 closed record reviews. The findings include: Resident #18 was admitted to the facility on 6/18/08 and re-admitted on 7/14/08 with diagnoses of intercranial hemorrhage, hypertension, atrial fibrillation and reflux disease. The resident passed away at the facility on 9/1/08. A review of the Inventory Sheet for Resident #18 showed an admission signature on 7/14/08, but no signature or date at discharge to indicate the responsible party had received the personal belongings of the resident. Nurses notes for 9/1/08 documented the removal of the body by the mortician, but did not contain any information on the disposition of the resident's belongings. On 12/4/08 at 10:00 am, the Director of Medical Records was interviewed. She reviewed the closed record and was unable to find any indication that Resident #18's belongings had been picked up by the responsible party. She stated, "It should have been signed or noted in nurses notes."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135077	A. BUILDING _____ B. WING _____	12/05/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOISE HEALTH & REHAB CENTER	1001 SOUTH HILTON STREET BOISE, ID 83705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations were cited during the annual Recertification survey of your facility. Surveyors conducting the survey were: Karen Marshall, MS, RD, LD, Team Coordinator Lea Stoltz, QMRP Lynda Evenson, BS, RN Amanda Bain, RN Sue Ferguson, BS, RN Survey Definitions: MDS = Minimum Data Set RAI = Resident Assessment Instrument RAPS = Resident Assessment Protocol DON = Director of Nursing LN = Licensed Nurse RN = Registered Nurse CNA = Certified Nurse Aide ADL = Activities of Daily Living MAR = Medication Administration Record PRN = As needed FDA = Food and Drug Administration	F 000	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Boise Health and Rehabilitation does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the center admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The center reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency. RECEIVED DEC 30 2008 FACILITY STANDARDS	
F 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS AND SERVICES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.	F 156	F156 **Resident Specific** The ID (inter-disciplinary) team reviewed resident # 4 related to the resuscitation status as noted in the statement of deficiency. As noted, it was updated with the appropriate physician order. **Other Residents** The ID team reviewed other residents for appropriate advance directives and physician orders. No other concerns were noted. **Facility Systems** Resuscitation status is reviewed upon admission and with significant changes in	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Executive Director — 12/30/08

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 156	Continued From page 1 The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.	F 156	condition as indicated. The advance directive is approved and signed by the resident or responsible party and approved by the physician through an order. The order will be processed and carried forward on the physician recapitulation of orders for regular review by the physician as required. **Monitor** The Director of Nurses (DNS) and/or designee will review one resident weekly for appropriate advance directives and physician orders. Any concerns will be addressed immediately and discussed with the PI (Performance Improvement) committee as indicated. The PI committee may adjust the frequency of the monitoring, as it deems appropriate. **Date of Compliance** January 9, 2009	

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F 156	Continued From page 2 A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.	F 156		

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F 156	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to update a resident's advance directive on the resident's Physician's Orders. This affected 1 of 11 (#4) sampled residents. Findings include: Resident #4 was originally admitted to the facility on 3/10/08, and readmitted on 9/28/08, with diagnoses of cerebrovascular accident and hemiplegia/hemiparesis. Resident #4's November 2008 Physician's Orders (recapitulation) documented the resident's code status was "Resuscitate" on 9/29/08. The resident's Consent for Do Not Resuscitate form, dated 11/20/08, documented, "No, I do not wish Cardiopulmonary Resuscitation [CPR] efforts in the event of cardiac arrest." On 12/2/08 at 10:55 a.m., the LN stated, "I must have forgotten to update the doctor's orders. The resident had a decline in condition, did not want CPR and the resident's power of attorney signed the no CPR on 11/20/08. The resident's doctor is in the facility. I will obtain the doctor's signature for a new order right now." At 11:35 a.m., the LN provided the survey team with a Physician Telephone Order signed by the resident's doctor that clarified the resident's advance directive status to no CPR. On 12/2/08 at 2:50 p.m., the Administrator and the DON were informed of the update to the Physician's Orders for the resident's CPR status.	F 156		
F 280	483.20(d)(3), 483.10(k)(2) COMPREHENSIVE	F 280		

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F 280 SS=D	Continued From page 4 CARE PLANS The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, it was determined the facility failed to review and revise care plans for 3 of 17 sampled residents (#3, #6 and #10) to reflect current resident status. In addition, the facility failed to ensure current care plan goal dates for 2 of 17 sampled residents (#4 and #17). Findings include: 1. Resident #3 was admitted to the facility on 01/21/08 with diagnoses of aftercare internal fixation device, urinary tract infection, osteoporosis, chronic kidney disease and hypertension.	F 280	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Boise Health and Rehabilitation does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the center admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The center reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency. F280 **Resident Specific** The ID team reviewed resident #'s 3, 6 & 10 related to their current condition and updated the plans of care as indicated. In addition, the ID team reviewed resident #'s 4 and 17 related to care plan goal dates. The dates were updated as indicated. **Other Residents** The ID team will review other residents with recent changes in condition to ensure the plans of care are accurate and current. In addition, each resident will be reviewed over the quarter as they come due for their routine assessments. The plans of care will be closely reviewed and updated with current status and goal dates as indicated. Finally, in-service education will be provided to licensed staff related to the center's care plan process to maintain current plans of care with accurate information and goal dates.	

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F 280	Continued From page 5 The significant change MDS assessment, dated 10/03/08, documented the resident: * received intravenous medication and a mechanically altered diet, --Note: the MDS did not document the resident was tube fed. * was incontinent of bowel and bladder and required extensive assistance with transfer and toileting. The resident's Comprehensive Care Plan Report (care plan), dated 10/17/08, was not updated to reflect the resident's current status in the following areas: a. The 12/26/07 care plan approach for the problem "risk for falls" stated that the resident should be toileted every 2 hours during waking hours and every 4 hours at night. The 7/15/08 care plan approach for the problem "self-care deficit: toileting" stated prompted voiding was to be done at 7:00 a.m., 9:00 a.m., 11:00 a.m., 2:00 p.m., 5:00 p.m. and 8:00 p.m." The care plan documented both toileting interventions as current approaches. The DON, a RN, and a LN were interviewed on 12/03/08 at 1:35 p.m. The RN stated, "The current care plan approach for toileting was prompted voiding, not toileting every 2 or 4 hours. The care plan needs to be updated." b. The 1/21/08 care plan approach for the problem, "risk for falls" stated "pressure pad alarm on in bed, wheelchair and lounge chair to alert staff of attempts to transfer independently." Observations on 12/1/08 and on 12/2/08 failed to	F 280	**Facility Systems** Residents are assessed upon admission, with change of condition and at least quarterly. Based on the assessment, a plan of care is developed and implemented. With subsequent changes in status or condition, the LN or ID team member will update the plan of care as indicated. The change of condition form or three-part tool will be the primary source for updating the plan of care with condition changes. **Monitor** The DNS and/or designee will review at least one plan of care each week to monitor for accuracy and current goal dates. Any concerns will be addressed immediately and discussed with the ID team and PI committee as indicated. The PI committee may adjust the frequency of the monitoring, as it deems appropriate. **Date of Compliance** January 9, 2009	

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F 280	Continued From page 6 verify that alarms were used on the bed, wheelchair and lounge chair. The DON, a RN and a LN were interviewed on 12/3/08 at 1:35 p.m. and were made aware of the lack of pressure pad alarms. At 1:55 p.m., the RN and surveyor observed the resident's bed, wheelchair and lounge chair and found no pressure pad alarms in place. At 2:15 p.m., the RN stated that the pressure pad alarms were discontinued by physical therapy "a few weeks ago" because the resident no longer self-transferred. The RN stated, "The care plan needs to be updated." c. The 9/29/08 care plan approach for the problem "comfort, altered, pain," stated, "tube feeding as ordered, resident is dependent upon staff to receive feeding." Review of the medical record failed to document an order for tube feedings. The DON, a RN and a LN were interviewed on 12/3/08 at 1:35 p.m. The RN stated the resident never had tube feedings ordered and that the care plan would need to be updated. d. The following care plan problems, dated 9/29/08, with goal dates of 1/6/09 and their related care plan approaches were still active at the time of the survey. *The care plan problem documented "potential for bleeding r/t [related to] Lovenox tx [treatment]." Lovenox was discontinued on 10/4/08 after the last dose was administered as ordered by the physician. *The care plan problem documented "infection:	F 280	.	

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F 280	Continued From page 7 potential for/ actual r/t receiving IV [intravenous] abts [antibiotics] via PICC [peripherally inserted central catheter] line. The PICC line was discontinued on 10/15/08 as ordered by the physician. *The care plan problem documented "intravenous fluids r/t UTI [urinary tract infection] r/t treatment with IV abt [antibiotic] via PICC line. The IV antibiotics were discontinued after the last dose was given on 10/7/08 as ordered by the physician. The DON, a RN and a LN were interviewed on 12/3/08 at 1:35 p.m. The RN stated that the care plan needed to be updated. 2. Resident #10 was admitted to the facility on 2/11/07, and readmitted on 11/28/08, with the diagnoses of blood sugars out of control with mental status changes, dementia with behavioral disturbances, depression, chronic obstructive pulmonary disease, Alzheimer's disease and bipolar disorder. The annual MDS assessment, dated 10/7/08, documented that the resident was taking antipsychotic medications 6 days a week and antidepressants 7 days a week. a. The care plan included the following approaches for medication administration and monitoring of Depakote, Seroquel, Celexa, and Detrol: *The care plan approach on 07/31/08 stated "continue anti-depressant as ordered for depression." *The care plan approach on 10/16/08 stated	F 280		

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F 280	Continued From page 8 "Depakote, Seroquel, Celexa-monitor for adverse effects and effectiveness." *The care plan approach on 07/23/07 stated "administer & monitor effectiveness of psychotropic meds as ordered. Monitor for side effects/effectiveness and document." *The care plan approach on 5/1/08 stated "administer Seroquel and Depakote as ordered for bipolar disorder-see medication record. Monitor effectiveness & side effects." *The care plan approach on 6/23/08 stated "administer medications as ordered: Detrol." The medical record review documented these medications were not reordered after the resident's readmission to the facility on 11/28/08. The DON, a RN and a LN were interviewed on 12/3/08 at 1:35 p.m. The RN verified that the care plan currently in the medical record, dated 11/18/08, was the interim care plan after readmission. The RN stated that the care plan needed to be updated. b. Resident #10's care plan, dated 11/18/08, also did not identify oxygen therapy as a problem area or contain an update for oxygen therapy. The resident's record included physician's orders, dated 11/28/08, for oxygen at 3 liters per minute via nasal cannula. On 12/4/08 at 10:25 a.m., the DON and a RN stated that oxygen therapy should be on the care plan. 3. Resident #17 was admitted to the facility on 3/9/06, and readmitted on 1/11/08, with diagnoses of chronic airway obstruction, aortic	F 280	.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOISE HEALTH & REHAB CENTER	1001 SOUTH HILTON STREET BOISE, ID 83705

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F 280	Continued From page 9	F 280		

valve disease, hypertension and esophageal reflux.

Resident #17's Comprehensive Care Plan Report, dated 7/20/08, identified 18 problems. Fifteen of the 18 problem areas had goal dates prior to the beginning of the survey. The goal dates were all 9/23/08.

On 12/4/08 at 10:45 a.m., the DON agreed the goals dates were not updated.

4. Resident #6 was originally admitted to the facility on 8/4/03, and readmitted on 4/3/07, with the diagnosis of multiple sclerosis.

The resident's Comprehensive Care Plan Report (Care Plan), dated 11/01/08, did not contain an oxygen therapy problem area or a handwritten update for oxygen therapy.

A review of the resident's chart revealed a Physician Telephone Order, dated 11/12/08, for oxygen at 2 liters per minute by way of nasal canula if oxygen saturations were below 90%. In addition, the nurse's notes documented that the nursing staff consistently monitored the resident's oxygen saturations and the saturations were consistently above 90%.

On 12/1/08 at 2:44 p.m. and again on 12/2/08 at 7:46 a.m., the resident was observed lying in bed wearing a nasal canula. The oxygen concentrator located adjacent to the resident's bed indicated an oxygen flow at 1.5 liters.

On 12/2/08 at 11:15 a.m., at 12:02 p.m., at 12:35 p.m., and at 2:20 p.m., on 12/308 at 10:58 a.m. and at 5:00 p.m., the resident was observed

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F 280	Continued From page 10 wearing a nasal canula attached to an oxygen canister. On 12/4/08 at 10:45 a.m. the DON stated, "Oxygen therapy should be on the resident's care plan." 5. Resident #4 was originally admitted to the facility on 3/10/08, and readmitted on 9/28/08, with diagnoses of cerebrovascular accident and hemiplegia/hemiparesis. Resident #4's Comprehensive Care Plan Report (Care Plan), dated 7/23/08, identified 17 problem areas. Sixteen of the 17 problem areas had goal dates prior to the beginning of the Recertification survey, 12/1/08. The prior goal dates ranged from 9/23/08 to 11/28/08. * 10 goal dates were 9/23/08 * 1 goal date was 9/30/08 * 3 goal dates were 10/29/08 * 1 goal date was 10/31/08 * 1 goal date was 11/28/08 On 12/4/08 at 10:45 a.m., the DON agreed the resident's Care Plan goal dates were not updated.	F 280	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Boise Health and Rehabilitation does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the center admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The center reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.	
F 323 SS=E	483.25(h) ACCIDENTS AND SUPERVISION The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 323		

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F 323	Continued From page 11 Based on observation, record review, staff interviews, and review of facility policy, it was determined the facility failed to ensure the environment remained free from accident hazards. A gait belt was incorrectly applied on 1 of 22 sampled residents (#3). Wheelchair arm rests were cracked or torn on 5 of 22 sampled residents (#5, #17, #21, #22 and #23). Hand held telephones were inappropriately positioned on the over-bed light for 3 of 22 sampled residents (#23, #24 and #25). Potentially hazardous chemicals were found in 2 unlocked rooms. This had the potential to affect all ambulatory cognitively impaired residents in the facility. Findings included: 1. Resident #3 was admitted to the facility on 01/21/08 with diagnoses of aftercare internal fixation device, urinary tract infection, osteoporosis, chronic kidney disease and hypertension. The significant change MDS assessment, dated 10/3/08, documented the presence of skin tears or cuts other than surgery. The Comprehensive Care Plan Report (care plan), dated 10/17/08, included care plan approaches to "avoid friction and shearing..." Mosby's Textbook for Nursing Assistants, 6th Edition" by Sheila A Sorrentino states on p. 257 in the text box "Applying a Transfer Belt: Apply the belt around the person's waist over clothing. Do not apply it over bare skin." The facility policy "PRO 51008", dated 05/28/08, entitled "Gait Belts" included the following procedure: "2. Place the belt around the resident's waist: a. Over the nightgown, clothing,	F 323	F 323 **Resident Specific** The ID team reviewed each of the residents noted in the statement of deficiency. Specifically, the staff member observed using the gait belt that was against the skin in the back due to the open hospital gown for resident # 3, was re-educated on proper application. The wheel chair arm rests for resident #'s 5, 17, 21, 22, and 23 will be replaced. As noted in the statement of deficiency, the telephones were removed from the over bed lights for resident #'s 23, 24, and 25. Finally, the body splash and lotion in the whirlpool room as well as the gel in the open storage room were secured immediately. **Other Residents** The executive director (ED) and the director of nursing rounded in the center to observe for other potential hazards including, but not limited to unsecured chemicals, torn or worn upholstery, and telephones on over bed lights. Corrections were made immediately as indicated. Additionally, in-service education will be provided to care center staff regarding environmental hazards and ensuring a safe environment. Specifically addressed will be monitoring and reporting torn upholstery, securing all chemicals and avoiding putting phones or other objects on over bed lights. **Facility Systems** The facility maintenance director will complete monthly prevention rounds to validate hazards are eliminated. Additionally, staff will address any hazard concern immediately and notify the	

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F 323	Continued From page 12 etc. (to protect the resident's skin)" On 12/2/08 at 7:15 a.m., Resident #3's a.m. care was observed. The CNA positioned the resident on the side of the bed. The resident was clothed in a hospital-like gown that was tied at the neck and open in the back. The CNA applied the gait belt around the resident directly on the resident's skin on his/her back. The resident was then transferred from the bed to the wheelchair. The DON, a RN and the RN consultant were informed of the gait belt transfer on 12/4/08 at 11:30 a.m. No further information was provided. 2. On 12/1/08 at 3:10 p.m., an unlocked bedside stand in the unlocked whirlpool room was observed to contain body splash and lotion with label warnings "for external use only." The warning "do not use in or around eyes" was also on the lotion bottle. On 12/1/08 at 3:20 p.m., the open storage room across from resident room 110 was observed to contain an open container of conductor transmission gel with the label warning "for external use only." The administrator and DON were made aware of these issues on 12/1/08 at 3:50 p.m. The administrator stated he would take care of the problem. 3. On 12/2/08 at 1:30 p.m. and on 12/4/08 at 8:55 a.m., the hand held telephones in Resident's #23, #24 and #25 rooms were observed to be positioned on top of the over-bed light which was affixed to the wall. The phone cord and the light cord were in close proximity (approximately 5	F 323	maintenance director as indicated. Finally, residents are assessed upon admission, with changes in condition and at least quarterly related to risks and hazards. Any concerns are reported and will be addressed immediately. **Monitor** The ED will round in the center at least weekly to monitor for potential hazards including, but not limited to unsecured chemicals, torn or worn upholstery, and telephones on over bed lights. Any concerns will be addressed immediately and discussed with the PI committee as indicated. The PI committee may adjust the frequency of the monitoring, as it deems appropriate. **Date of Compliance** January 9, 2009	

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F 323	Continued From page 13 inches or less). The resident's beds were positioned against the wall under the over-bed light. Resident #24 demonstrated he/she could reach the phone cord dangling beside the light cord. This presented a hazard if the resident pulled on the telephone cord instead of the light cord causing the phone to fall on him/her. Two CNAs were interviewed about the position of the phones on the over-bed light on 12/4/08 between 8:55 a.m. and 9:10 a.m. One CNA stated that phones that were not in use were stored on the over-bed light. The second CNA stated that the phone may have been placed there when making the bed and then left there. A third CNA was interviewed on 12/208 at 2:00 p.m. He/she stated he/she never noticed that the phones were on the over-bed lights and could not explain why they would be there. The DON was made aware of the issue on 12/4/08 at 9:10 and took the phone down from the over-bed light for Resident #23. The administrator was made aware of the issue 12/4/08 at 11:30 a.m. 4. During dining observation on 12/3/08 from 5:00 p.m. to 5:30 p.m. the following wheelchairs were noted to pose a potential skin tear hazard to the residents: a. Resident #21's right wheelchair arm was noted to have a torn cover. The rounded end of the arm upholstery was lifted, exposing a jagged edge. b. Resident #22's right wheelchair arm upholstery was cracked in several places, exposing jagged	F 323		

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F 323	Continued From page 14 edges. c. Resident #23's left wheelchair arm upholstery was cracked in several places, exposing jagged edges. d. Resident #17's left wheelchair arm upholstery was cracked in several places with jagged edges, exposing the resident to potential skin tears. 5. Resident #5 was originally admitted to the facility on 11/10/06, and readmitted on 7/18/08, with diagnosis of pressure ulcer and quadriplegia. Resident #5's quarterly MDS assessment, dated 10/20/08, documented the resident's skin was desensitized to pain or pressure. On 12/3/08 at 12:05 p.m., the resident's motorized wheelchair was observed with a loose left black plastic armrest. In addition, the armrest was cracked in two different locations along the front edge and cracked in one location along the outside edge. The cracks along the front edge created a jagged edge to the plastic armrest. The surveyor asked the resident his/her opinion of the left armrest. The resident replied with, "It is loose and cracked." The cracked armrest presented a hazard to a resident whose skin became desensitized to pain or pressure. On 12/4/08 at 11:30 a.m., the DON was informed of the left armrest on Resident #5's motorized wheelchair.	F 323	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Boise Health and Rehabilitation does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the center admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The center reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.	
F 328 SS=D	483.25(k) SPECIAL NEEDS The facility must ensure that residents receive	F 328		

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F 328	Continued From page 15 proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, it was determined the facility failed to consistently monitor the resident's oxygen saturation levels and oxygen liter flow. This was true for 1 of 7 (# 17) residents sampled. Findings include: Resident #17 was admitted to the facility on 3/9/06 and readmitted on 1/11/08 with diagnoses of chronic airway obstruction, aortic valve disease, hypertension and esophageal reflux. The resident's record included physician's orders, dated 2/19/08, for oxygen at 2 liters per minute via nasal cannula to keep oxygen saturations greater than or equal to 90%. The MAR documented that oxygen checks for liters per minute and saturations were not recorded for the following dates and shifts in November 2008: *day shift: 11/16 and 11/26 *evening shift: 11/30 *night shift: 11/22, 11/23, 11/28, and 11/29	F 328	F 328 **Resident Specific** The ID team reviewed resident # 17 related to Oxygen use and monitoring. The physician order and plan of care were updated as appropriate. **Other Residents** The ID team will review other residents receiving oxygen therapy to ensure appropriate orders and monitoring as indicated. **Facility Systems** Residents that are assessed to require oxygen therapy are assessed for need and a proper physician order is obtained and followed. When on-going monitoring is required, a nurse will check saturation levels at least each shift and record the results on the medication administration record. More frequent monitoring may be done as deemed appropriate by the nursing staff or per physician direction. **Monitor** The DNS and/or designee will review at least one resident weekly with oxygen therapy orders to ensure an appropriate physician order and adequate monitoring is completed and documented. Any concerns will be addressed immediately and discussed with the PI committee as indicated. The PI committee may adjust the frequency of monitoring, as it deems appropriate. **Date of Compliance** January 9, 2009	

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F 328	Continued From page 16 On 12/4/08 at 10:25 a.m., the DON and an RN were informed of the lack of documentation. No further information was received regarding the documentation issue.	F 328	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Boise Health and Rehabilitation does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the center admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The center reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.	
F 371 SS=F	483.35(i) SANITARY CONDITIONS The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to prepare food under sanitary conditions. This applied specifically to the residue build up on the frame of the industrial stand up mixer in the facility's kitchen. This affected 22 of 25 sampled residents (#s 1-17 & #s 21-25) and had the potential to affect all residents who dined in the facility. Findings include: On 12/1/08 at 11:45 a.m. during the initial tour of the facility's kitchen, the industrial stand up mixer was observed not in use. The Food Services Director indicated the mixer was just used to whip the lunch dessert topping. The whipped topping was in the mixing bowl, was of a white color, and was positioned on a kitchen cart not on the mixer. The mixer frame area above where the mixing bowl would be positioned during food preparation	F 371	F 371 **Resident Specific** The frame of the industrial stand up mixer was cleaned immediately prior to use again. The ID team observed residents, including #'s 1-17 & 21-25, for evidence of food borne illness. None was noted. **Other Residents** The food service manager and the ED rounded in the kitchen to ensure that the food preparation areas and equipment were clean and sanitary. In-service education will be provided to kitchen personnel related to cleaning requirements including preparation equipment. **Facility Systems** The kitchen including food preparation areas and equipment are keep clean and sanitary. Equipment is cleaned in between use. Additionally, the kitchen is monitored routinely by the food service manager and registered dietician to ensure cleanliness and sanitary cooking conditions.	

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F 371	Continued From page 17 had five white splatters of what appeared to be whipped topping. The area also contained what appeared to be dried food debri splatters of a brownish color. The mixer frame area located behind where the mixing bowl would be positioned during food preparation also contained what appeared to be dried food residue of a reddish color. The Food Services Director agreed the mixer frame was in need of cleaning. The 2005 FDA Food Code, Chapter 4, Subsection 601.11, Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils indicates, "(C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris." Subsection 602.13, Nonfood Contact Surfaces indicates, "Nonfood-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues." The State Operations Manual (SOM), Revision 36, dated 8/1/08, indicates."When cleaning fixed equipment (e.g. [example given] mixers, slicers, and other equipment that cannot readily be immersed in water), the removable parts are washed and sanitized and non-removable parts are cleaned with detergent and hot water, rinsed, air-dried and sprayed with a sanitizing solution (at the effective concentration)..."	F 371	**Monitor** The ED and/or designee will round in the kitchen at least weekly to observe for cleanliness and sanitary conditions. Any concerns will be addressed immediately and discussed with the PI committee as indicated. The PI committee may adjust the frequency of the monitoring, as it deems appropriate. **Date of Compliance** January 9, 2009 This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Boise Health and Rehabilitation does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the center admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The center reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.	
F 444 SS=D	483.65(b)(3) PREVENTING SPREAD OF INFECTION The facility must require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted	F 444		

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F 444	Continued From page 18 professional practice. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and review of facility policy, it was determined that the facility failed to ensure staff providing perineal care washed their hands before proceeding with subsequent care for 1 of 17 residents (#3). Findings include: According to October 25, 2002, Center for Disease Control guidelines, "The use of gloves does not eliminate the need for hand hygiene. Likewise, the use of hand hygiene does not eliminate the need for gloves. Gloves reduce hand contamination by 70 percent to 80 percent, prevent cross-contamination and protect patients and health care personnel from infection." The facility's policy entitled "Handwashing", dated 04/28/07, stated "The hands are to be washed: between tasks and procedures on the same resident when contaminated with body fluids to prevent cross-contamination of different body sites; after removal of medical/surgical or utility gloves." Resident #3 was admitted to the facility on 01/21/08 with diagnoses of aftercare internal fixation device, urinary tract infection, osteoporosis, chronic kidney disease and hypertension. Resident #3's care was observed at 7:15 a.m. on 12/02/08. After completing perineal care and changing the incontinent briefs with gloved hands, the CNA removed the gloves but did not	F 444	F 444 **Resident Specific** The DNS personally met with the staff member noted in the statement of deficiency related to hand washing to re-educate on the requirements. Additionally, the ID team reviewed resident # 3 related to possible infection. None was noted. **Other Residents** The DNS and ED rounded in the center to observe for proper hand washing and providing re-education regarding the requirements. Additional in-service education will be provided to direct care staff regarding hand washing. **Facility Systems** The center has specific policies and procedures to address infection control and hand washing as noted in the statement of deficiency. Direct care staff are in-serviced on proper hand washing upon hire, annually and as needed thereafter. Licensed nurses observe cares and ensure compliance with infection control measures. **Monitor** The DNS and/or designee will round in the center at least weekly and observe personal cares to ensure proper hand washing. Any concerns will be addressed immediately and discussed with the PI committee as indicated. The PI committee may adjust the frequency of the monitoring, as it deems appropriate. **Date of Compliance** January 9, 2009	

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F 444	Continued From page 19 decontaminate his/her hands before transferring the resident to the wheelchair and dressing the resident. At approximately 9:00 a.m. on 12/02/08, the CNA was interviewed and acknowledged that he/she had not washed their hands after removing the gloves following perineal care. The DON, nurse consultant and the administrator were informed about the lack of hand washing on 12/4/08 at 11:30 a.m. No further information was provided.	F 444		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135077	A. BUILDING _____ B. WING _____	12/05/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOISE HEALTH & REHAB CENTER	1001 SOUTH HILTON STREET BOISE, ID 83705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	16.03.02 INITIAL COMMENTS The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2. The following citations were cited during the Strate licensure survey of your facility. Surveyors conducting the survey were: Karen Marshall, MS, RD, LD, Team Coordinator Lea Stoltz, QMRP Lynda Evenson, BS, RN Amanda Bain, RN Sue Ferguson, BS, RN Survey Definitions: MDS = Minimum Data Set RAI = Resident Assessment Instrument RAPS = Resident Assessment Protocol DON = Director of Nursing LN = Licensed Nurse RN = Registered Nurse CNA = Certified Nurse Aide ADL = Activities of Daily Living MAR = Medication Administration Record PRN = As needed FDA = Food and Drug Administration	C 000	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Boise Health and Rehabilitation does not admit that the deficiencies listed on the State Form exist, nor does the center admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The center reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency. RECEIVED DEC 30 2008 FACILITY STANDARDS	
C 119	02.100,03,c,iii iii. Is fully informed, by a physician, of his medical condition unless medically contraindicated (as documented, by a physician, in his medical record), and is afforded the opportunity to participate in the planning of his medical treatment and to refuse to participate in	C 119	Refer to the Plan of Correction for F 156	

Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Executive Director — (X6) DATE: 12/30/08

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135077	A. BUILDING _____ B. WING _____	12/05/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOISE HEALTH & REHAB CENTER	1001 SOUTH HILTON STREET BOISE, ID 83705

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C 119	Continued From page 1 experimental research; This Rule is not met as evidenced by: Please refer to F156 as it related to the resident's advance directive not updated on the resident's Physician's Orders.	C 119	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Boise Health and Rehabilitation does not admit that the deficiencies listed on the State Form exist, nor does the center admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The center reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency. As noted in the statement of deficiency, the appropriate annotation was made on the week 2 Menu updating the substitutions. The food service manager and registered dietician reviewed the rest of the menu to ensure than any other adjustments were properly annotated. The registered dietician reviewed the policy and requirements with the food service manager to ensure compliance going forward. The registered dietician will review menu changes and ensure proper annotation in the future. The ED and/or designee will review menus at least weekly to ensure compliance with any changes. Any concerns will be addressed immediately and discussed with the PI committee as indicated. The PI committee may adjust the frequency of the monitoring, as it deems appropriate. The date of compliance will be January 9, 2009.	
C 299	02.107,05,c c. Menus shall be prepared at least a week in advance. Menus shall be corrected to conform with food actually served. (Items not served shall be deleted and food actually served shall be written in.) The corrected copy of the menu and diet plan shall be dated and kept on file for thirty (30) days. This Rule is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to annotate corrections to the facility's Week 2 menu when changes to the food served were made. Findings include: On 12/2/08 at 12:02 p.m. during the lunch meal observation, the survey team observed some residents eating pork chops, rice pilaf, and vegetables. Some residents were observed eating meat loaf and harvard beets. On 12/2/08 at 2:30 p.m., the survey team observed the menu board on the wall outside of the Teton dining room. The menu board documented the lunch main entree was Asian pork chop, rice pilaf, and stir fry vegetables. The alternate for the lunch meal was meat loaf and harvard beets. A review of the facility's Week 2 menu revealed the scheduled 12/2/08 lunch meal was Asian pork	C 299		

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C 299	Continued From page 2 chop, rice pilaf, and stir fry vegetables and the alternate was paprika fish and whole kernel corn. On 12/3/078 at 12:35 p.m., the surveyors asked to review the facility's Week 2 menu for any documented substitutions or corrections for the lunch meal on 12/2/08. The Food Services Director (FSD) stated, "The Week 2 menu was not updated to include the meat loaf and harvard beets substituted for lunch yesterday. We made the change because we did not receive a shipment of fish." The FSD immediately annotated the 12/2/08 alternate lunch menu changes to the Week 2 menu maintained in the FSD's office.	C 299		
C 325	02.107,08 FOOD SANITATION 08. Food Sanitation. The acquisition, preparation, storage, and serving of all food and drink in a facility shall comply with Idaho Department of Health and Welfare Rules, Title 02, Chapter 19, "Rules Governing Food Sanitation Standards for Food Establishments (UNICODE)." This Rule is not met as evidenced by: Please refer to F371 as it related to the food debris and residue on the industrial stand up mixer.	C 325	Refer to the plan of correction for F 371	
C 342	02.108,04,b,ii ii. All toxic chemicals shall be properly labeled and stored under lock and key. This Rule is not met as evidenced by: Please refer to F323 as it relates to the security of potentially hazardous chemicals.	C 342	Refer to the plan of correction for F 323	

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C 386	02.120,03,a a. The building and all equipment shall be in good repair. This Rule is not met as evidenced by: Please refer to F323 as it relates to ensuring equipment is kept in good repair.	C 386	Refer to the plan of correction for F 323	
C 672	02.150,03,c c. Exhibited knowledge by staff in controlling transmission of disease. This Rule is not met as evidenced by: Please refer to F444 as related to handwashing.	C 672	Refer to the plan of correction for F 444	
C 781	02.200,03,a,iii iii. Written to include care to be given, goals to be accomplished, actions necessary to attain the goals and which service is responsible for each element of care; This Rule is not met as evidenced by: Please refer to F328 as it related to the plan of care to be given regarding oxygen therapy and oxygen saturations.	C 781	Refer to the plan of correction for F 328	
C 782	02.200,03,a,iv iv. Reviewed and revised as needed to reflect the current needs of patients/residents and current goals to be accomplished; This Rule is not met as evidenced by: Please refer to F280 as it related to revision of care plans.	C 782	Refer to the plan of correction for F 280	